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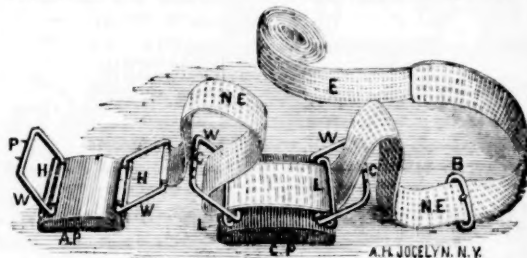
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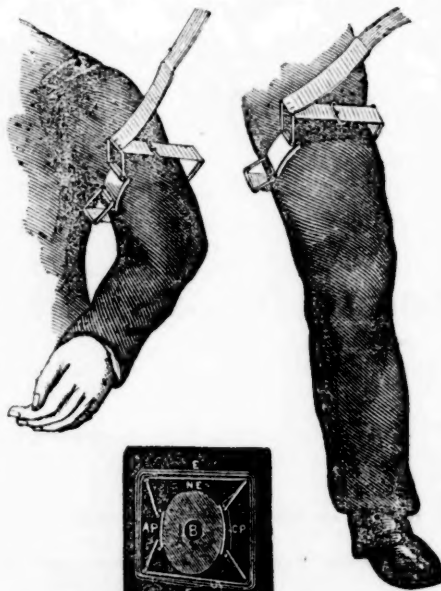
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Original Lectures.

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By HENRY D. NOYES, M.D.,

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LECTURE III.

ENTROPION—ECTROPION.

Entropion.—The border of the eyelid may be turned upon the globe in consequence, first, of great laxity of the lids; second, of spasm of the orbicularis; third, of shrinking of the conjunctiva and fibro-cartilage. The first of these causes is a passive condition found sometimes in old persons; the second is a frequent accompaniment of other ocular disease, as keratitis, but is seldom a primary affection; the third is by far the most frequent cause of entropion.

If the ciliary border curls inwards, simply from redundancy and relaxation of the eyelids, excision of a portion of the skin will readily relieve it. Temporary relief is given by pencilling the lid daily with contractile collodion. Spasmodic entropion sometimes occurs in chronic conjunctivitis and keratitis. This is often the case with children. The photophobia incident to the primitive disease induces muscular spasm, and if entropion be produced, the fretting of the cornea by the cilia in its turn increases the severity of the ocular inflammation. This is the vicious circle which obtains in many protracted cases of so called serofulous ophthalmia. The remedy for it is to divide the orbicularis by a horizontal incision extending from the outer angle for the length of half an inch. Leave the wound to granulate, and before it will have united enough to restore to the orbicularis its full contractility, treatment may so far modify the ocular disease as to get rid of the excessive photophobia. This little operation would hasten the recovery of many cases which persist for months.

Spasmodic entropion occurs also under conditions of less severity than the above. The palpebral portion of the orbicularis is at fault. It will be seen that there is no deformity of the lids, and that it is easy to redress the entropion with the fingers. To relieve such cases it is necessary to excise those fibres of the orbicularis which lie nearest the cilia, together with a narrow strip of skin. The width of the strip of skin need not be more than a quarter or three-eighths of an inch, but the muscular fibres which present themselves should all be carefully dissected off the surface of the tarsal cartilage. This dissection requires the aid of a spatula beneath the lid held by an assistant, or of Snellen's forceps. The edges of the wound may be united by sutures.

But the most important and most numerous cases of entropion are the result of chronic inflammation of the lids. Wherever granular conjunctivitis prevails entropion will be one of its sequelae. It is found abundantly among the poor of large cities. It is of great importance to bear in mind how the deformity originates. There has been chronic ophthalmia tarsi, or granular conjunctivitis—the palpebral conjunctiva has been hypertrophied, but now is atrophied, and white lines are traced upon its surface, denoting the abundance in it of fibrous tissue. Fibrous tissue becomes developed in the submucous tissue and in the fibro-cartilage—this subsequently undergoes contraction. These processes of degeneration, atrophy, and contraction, cause distortion. The tarsal border becomes thickened, the fibro-cartilage incurved, the cilia turn inwards, the palpebral fissure shortened and narrowed, the tarsal border and eyelids press forcibly upon the globe. To these organic lesions must be added spasm of the orbicularis, to give intensified vehemence to the existing troubles. Under these morbid conditions there is, of course, perpetual conjunc-

tival inflammation; the cornea, if not made opaque already by granular conjunctivitis, soon becomes hazy and vascular. Sometimes it changes shape, because softened by chronic inflammation and squeezed by the eyelids. I have seen several instances of staphyloma, especially of the upper half of the cornea, thus produced. If the disease continue long, complete pannus of the cornea will result. At any rate the patient is in constant distress, and his vision more or less impaired. The disease, moreover, has no tendency towards recovery.

The amount of distortion will vary with the duration and severity of the case. As soon as the eyelashes touch the globe irritation is produced, and to rectify their malposition has too often been the only object of the surgeon. Hence the fruitless operations upon the skin of the lid, as if there were nothing more than trichiasis. It must be borne in mind that all the tissues of the lid are involved, and the irritation of the eye may be due as much to the rubbing of the tense and shortened tarsus as to the contact of the cilia. The deformity of the fibro-cartilage may be easily seen in its external convexity, and further demonstrated by the difficulty of everting the lids with the fingers.

Treatment.—Removal of portions of the skin and orbicularis cannot and do not meet the indications of these cases. The eyelid may be shortened, but the stiff fibro-cartilage will not be restored to its normal shape. Inversion of the cilia is by this method very rarely overcome, while the harsh pressure of the tarsus is never relieved. I cannot speak too strongly of the futility of this operation; sometimes it does injury because the upper lid may be so much shortened as not to meet the lower lid, except by forced efforts; the conjunctiva is thus left exposed during sleep. Various proceedings have been adopted to correct the deformity of the fibro-cartilage, such as a transverse incision across the middle of the tarsus on its mucous surface, coupled with removal of a piece of skin; another is to split the tarsal cartilage into an anterior and posterior lamina by an incision made along its upturned free border, and then to remove a piece of skin; a more severe operation is to lift the eyelid off the globe, and turn it up against the forehead, making for this purpose a vertical incision through its whole thickness at each angle—the lid to be retained for several days in this everted position while the cut edges are touched with caustic. These operations succeed for a time, but when the cicatrices have contracted to their full degree the deformity returns.

These attempts proving so unsatisfactory many surgeons have abandoned the design of saving the eyelashes, and resort to the operation of "scalping the lids." Mr. Wilde, of Dublin, displays a large bottle full of such trophies, and we resort to it very commonly at the Eye Infirmary. In doing it a spatula is held beneath the lid by an assistant, both to support and to keep it tense; an incision is made through the skin close to and parallel with the border of the lid, and the fibro-cartilage exposed; next incise the tarsal border to the required depth, say a quarter of an inch at its outer angle, and at a point just external to the punctum; lastly, remove the border of the lid with the scissors. A sufficient width must be given to the strip removed to include the whole length of the hair follicles, and if stumps are found protruding from the cut edge they must be carefully cut away. The slight irregularity of the border which is caused by the use of scissors disappears as the wound heals. No sutures are needed or other dressing than cold water. It is not well to operate on both eyelids of the same eye at one sitting, because the raw edges will unite by adhesion. This accident has once occurred to me: the ankyloblepharon was easily removed by passing a probe between the lids. This operation gives relief in numerous cases at the expense of the eyelashes, and of a shortening of the eyelid which sometimes amounts to incomplete closure during sleep. But it sometimes does not fully remove the irritation of the eye. The eyelid rubs harshly over the cornea, because by atrophy and contrac-

tion of the tissues it has become incurvated and tightened. The remedy for this consists in a permanent elongation of the palpebral fissure. It is done in this way: a horizontal cut is made through the external commissure half an inch long; the wound is, by an assistant stretching it upwards and downwards, made vertical, and the conjunctiva is stitched by fine sutures to the skin. This relaxes the contraction of the orbicularis as well as the mechanical pressure of the lids.

This operation of extending the palpebral opening has been lately employed by several oculists in conjunction with the use of ligatures. Dr. Williams, of Cincinnati, has done this for several years. Dr. Pagenstecher, of Wiesbaden, Dr. Snellen, of Utrecht, have devised different methods of using the ligatures. I think the operations are promising enough to bring them to your notice, and I shall take an early opportunity of trying them. The first step is to cut through the outer angle, and sew the conjunctiva to the skin as I have described; the next step is, according to Pagenstecher, to pass two or three silk threads vertically through the lid, between the fibro-cartilage and the muscular layer, entering at the tarsal border, and emerging through the skin opposite the upper edge of the tarsus; the ligatures are then tied down tightly, and left to cut themselves out. The contraction of the cicatrices is said to succeed in maintaining permanent eversion. The process must be painful, and the skin marred by scars. Dr. Snellen's method is to keep the lid everted by only one ligature; the thread is armed at each end with a short curved needle; both needles are pushed entirely through the lid from its conjunctival surface at the upper border of the tarsal cartilage, the points of perforation being about a quarter of an inch apart; each needle is entered again through its puncture in the skin, and pushed down next to the external surface of the fibro-cartilage and beneath the muscular fibres, until it comes out at the ciliary border; the two ends of the thread are then firmly tied together. The ligature is left *in situ* for three days. It is necessary to pass the needles through the lid as far up to the *cul de sac* as possible, by strongly everting the lid, and the needles must not come out any higher than the ciliary edge. The loop of thread when tied bends the fibro-cartilage so as to make its external surface concave; and it does not create much inflammation of the skin or visible cicatrices like the ligatures of Pagenstecher. Dr. Snellen reports this ligature sufficient to cure moderate degrees of entropion without any enlargement of the palpebral slit. I should not be willing in bad cases to dispense with this valuable part of the proceeding.

It is very desirable to cure inveterate entropion without scalping the lid. If nothing else succeed, this method always remains—like amputation in a bad case of compound fracture of the leg.

Entropion.—This deformity occurs most frequently in the lower lid, while entropion is most severe in the upper lid. It may be spasmodic and occasional, or organic and permanent. Some persons have the power of voluntarily producing entropion. Spasmodic eversion sometimes occurs in infants when crying. The formation of their eyelids will predispose to this accident; the palpebral fissure will be too long or the lids be incompletely developed. A case of this kind was reported by me in the *MEDICAL TIMES* about a year ago. The eversion is produced by the strong contraction of the orbicularis, and remains after the paroxysm of weeping has ceased. The unnatural presentation of the red and swollen conjunctiva alarms the mother, and although easily replaced, its continued recurrence excites conjunctivitis.

Permanent ectropion is much more common than spasmodic, and is caused by thickening of the conjunctiva from chronic inflammation, by cicatrization of wounds, of ulcers, of burns, by caries of the orbit, by lupus, etc.

The annoyance it produces is constant epiphora, dryness and inflammation of the conjunctiva, excoriation of the skin, irritation of the globe, and perhaps keratitis.

Treatment.—Spasmodic ectropion may be overcome by uniting the edges of the lids for a distance of a quarter of an inch or more, as the case requires, at the outer angle. To do this the edges should be refreshed and united by sutures.

To prevent the occurrence of ectropion during the cicatrization of ulcers of the skin, it is recommended to close the palpebral fissure entirely until all tendency to contraction in the cicatrix has ceased. The entire tarsal borders are refreshed and united by sutures, with the exception of a perforation to let tears escape. When it is judged that the danger of ectropion has passed, the palpebrae are separated by simply dividing the line of junction. This is a proceeding I have never seen tried; it may be worth bearing in mind.

Slight degrees of ectropion resulting from chronic conjunctivitis are much relieved by slitting the inferior lachrymal canaliculus; this permits the tears to enter their proper channel, and treatment of the conjunctivitis becomes more satisfactory.

Ectropion from caries must not be attended to until the dead bone has been disposed of. The operation to be chosen for the deformity will depend upon its extent, and upon whether the skin is mobile. For the lower lid, when the skin is supple, a favorite operation is to make a V-incision, bringing the apex well down upon the cheek, raise the triangular flap, and slide it upwards; unite the edges by sutures, and also draw together the wound left by removal of the apex of the flap. By this proceeding from two to four lines may be gained in height of the tarsal border. The same operation is more rarely applied to the upper lid. If a greater effect is required, or if the skin is adherent to the bone, it is necessary to liberate the lid by incisions, and lift it to its place, and then to fill the gap by a flap transplanted from the neighboring skin. This flap may come from the temple, from the cheek, from the side of the nose, from the forehead. The pedicle may be below the middle of the lower lid far down upon the cheek, it may be at the root of the nose, or upon the temple. The essential points of success are to make the flap amply large, to give it a broad pedicle, to twist the pedicle as little as possible—it is rarely necessary to twist it through more than ninety degrees. Care must be taken to leave a strip of skin along the tarsal border to which to fasten the flap by sutures. The wound left by the removal of the flap may be partly united by stitches, and the rest left to granulate. Much may often be gained by extensive subcutaneous incisions of the adjacent skin. Plastic operations on the face are generally satisfactory, if only moderate skill is employed, because the skin is so vascular that there is little risk of sloughing of the flap.

I cannot describe them more minutely without the aid of diagrams, and these you will find in the books.

If ectropion is caused by a small cicatrix adherent to the bone it has been proposed to surround the scar by two curved incisions, whose direction shall be more or less perpendicular to the tarsal border, then to dissect up the adjacent skin by subcutaneous incisions, and unite the edges of the wound *above* the adherent scar, as it were burying it under the integument. This certainly would leave the eyelid more mobile, and perhaps would restore it to place.

After the eyelids have been restored to their proper position, by whatever operation, it often is needful to shorten the tarsal border by excising from it a wedge-shaped piece. The tarsus by its prolonged malposition has become stretched, and is too long for its natural situation. This trimming should, however, be deferred until several months after the original operation.

La Presse Médicale Belge says that M. the Senator Ribacourt has demanded, in the Upper Chamber, the establishment of chairs of homoeopathy in the universities of the kingdom. The question is not yet decided; and homoeopathy has, therefore, not yet obtained its official chair, salaried by the State.—*Brit. Med. Jour.*

Original Communications.

OBJECTIONS TO THE TREATMENT OF MORBUS COXARIUS

IN ITS ADVANCED STAGES BY EXTENSION, UNLESS PRECEDED BY TENOTOMY.

ILLUSTRATED WITH CASES AND ILLUSTRATIONS.

By LEWIS A. SAYRE, M.D.,

SURGEON TO THE BELLEVUE HOSPITAL.

SINCE the publication of my report on morbus coxarius to the American Medical Association, in June, 1860, the treatment of this disease by *extension* has become almost universal, and the plan of treatment suggested in the Report has been partially adopted, not only in all parts of this country but also in Europe.

On page 23 of my Report, when speaking of muscular contraction, I state—"But this *constant muscular contraction* exhausts the nervous system and induces hectic fever, gives the child nocturnal spasms of intense agony, caused by pressure of the head of the femur against the acetabulum, and produces absorption of both bones, and prevents nutrition of the limb, which results in atrophy. I, therefore, resort to artificial means to produce this rest and remove the pressure, and *formerly* divided the firmly contracted muscles to prevent the head of the bone from being pressed against the acetabulum, and kept them at rest in the horizontal position in the 'wire breeches' of Dr. Bauer; but now accomplish the same result by gradual but permanent extension by the means of the instrument I have devised, with very much more satisfactory results, and without any danger of ankylosis, or by a weight and pulley as suggested by Sir Benjamin Brodie."*

A more extensive experience has satisfied me that in the advanced periods of the disease we cannot succeed without tenotomy, and as I am partially responsible for the present almost universal treatment by extension, it is due to myself as well as to the profession that I should clearly explain my views in regard to its therapeutical effects.

The object of extension in the inflammation of all joints is to relieve pressure from the inflamed synovial membrane and cartilage. In the earlier stages of the disease *extension* alone will accomplish this object; but in all inflamed joints reflex contractions soon take place, and the muscles become secondarily involved in the disease, and continue thus to complicate it to its termination.

The muscles, by being kept in a state of permanent contraction for a long time, become *contractured*, or structurally shortened, and in this state cannot be stretched or elongated by any amount of extension short of rupture.

On the contrary, any attempt at extension of a muscle in this condition only irritates it the more, and by persistence will produce chronic inflammation of its fibres, which if continued will always end in fatty infiltration and degeneration, after which it will never be restored to its natural contractility and elasticity. And the constitutional effects of a persistent attempt to extend an inflamed muscle are really as bad, if not worse than would be produced by the disease if left to the unaided efforts of nature.

If the object to be accomplished is to relieve the inflamed synovial membrane from pressure, it is obvious that it can be done by extension *only* when the muscles are in a condition to be *extended*; but if they have become structurally shortened and absolutely incapable of *any elongation*, it is equally obvious that no separation of the inflamed surfaces

can take place without first making section of the *contractured** muscles.

In some instances the inflammation commences in the muscles, and the joint becomes secondarily involved: in these cases the views here expressed are of still greater importance, as extension will seriously aggravate all the symptoms, *rest* being absolutely requisite.

As I deem these views of vital importance in the treatment of chronic inflammation of *all joints*, and as I have seen a very large number of cases where the extension had been continued for months without benefit, but great injury, and which have been instantly relieved by subcutaneous tenotomy, I will narrate one or two to illustrate the principle which I have endeavored to inculcate in this paper:—

CASE I.—C. Pernot, aged 8, 156 Stanton street, was brought to my office in August, 1862, suffering from hip disease in its second stage, the result of a fall received sixteen months previously. She had had all the ordinary symptoms of the disease in its progressive stages, and at the time she was carried to my office she was much emaciated, had very little appetite, suffered intense pain, particularly at night, which was of a sharp lancinating character, and came on by spasms, requiring a very free use of morphine to induce sleep. The limb was immovably fixed in the distorted position of the second stage, and retained there by muscular contraction. Any attempt at motion produced the most intense suffering, and moved the entire pelvis without giving any motion in the joint. Dr. Prince took charge of the case, and applied extension by means of adhesive plaster to the leg, and a weight and pulley over the foot of the bed, the lower portion of which was raised in order to make the body act as a counter-extending force. No benefit whatever was derived from the treatment; but on the contrary her pain became more severe, she required a more liberal use of morphine, lost her appetite entirely, became very greatly emaciated, and at the end of three months the constitutional symptoms had become so much aggravated that the Doctor requested me to see her with him. He had varied the weight at different times from one pound up to eight, but all to no purpose, and he became satisfied that the extension was of no use, but was doing her a very positive harm.

I saw her on the sixteenth of December, and found her much worse than when she was at my office in August; she was much more emaciated, exceedingly irritable, and the tenderness around the joint so great as to preclude all possibility of motion. The adductor muscles of the thigh, the tens. vag. femoris, rectus, and sartorius were very tensely contracted and firm. She was put under chloroform, and I divided them subcutaneously with an immediate improvement of the position, and quite free motion of the joint. No hæmorrhage followed the operation. The wounds were instantly closed by adhesive plaster, without the admission of air; a cloth wet in cold water was applied and secured by a roller around the pelvis and thigh. One-fourth of the weight which had been formerly used was then applied to the foot, and she was left in the bed as before.

The next morning I called to see her, in company with Dr. Winslow Lewis, of Boston, and found her cheerful and happy, playing with her doll, entirely free from all pain, and had been so since the operation. She had taken no opiate, and yet had slept well all night without any spasms, which the mother stated was the first time she had slept well for many months.

From this time all her symptoms improved rapidly, her appetite returned, her sleep was perfect, and all constitutional irritation subsided. The wounds all healed in a few days without suppuration, and at the end of fourteen days I applied my short splint for extension from the thigh, and she immediately began to walk about without pain.

* I use the term *contractured* to express a shortened muscle, but which is still capable of being extended; and *contractured* when it has undergone structural shortening and is incapable of being elongated—similar to Barwell.

* Chelius' Surgery, edited by South, American reprint, page 296—also page 300.

In March last she walked from Stanton street to Bellevue Hospital to have her bandages re-applied, and was there exhibited to the students. The limb was nearly the same length as the other, and perfectly straight; the motions of the joint were free and without any pain, and her general health was good. When the instrument was properly adjusted she could bear her entire weight upon the diseased limb without pain, although when it was removed she could neither bear any weight upon it nor have it moved without great suffering. Of course many months will yet be required to effect a cure, but from the many similar cases that I have seen I am satisfied she will entirely recover, and with a useful joint.

CASE II.—The following case is from the reports of Bellevue Hospital, and is reported by W. F. Peck, M.D., Senior Assist. to First Surgical Division:—

Sabina Donelson, *et. 6 years*, is a well formed child, and had always been in the enjoyment of good health up to the commencement of her present trouble, which began August 1, 1861. Her mother states that she was standing on a table, when she accidentally received a fall which gave her some pain at the time. In a day or two after the accident she again engaged in her play as though nothing had happened, and continued to remain free from any unpleasant symptoms until early in October, when she was attacked with a severe pain in her knee, accompanying which there was a noticeable halting in her walk. Her mother thinks she observed this before the pain appeared. The pain, which was of a lancinating character, was most violent during the night. Her parents and others sleeping in adjoining rooms would frequently be disturbed with her justifiable shrieks.

About the middle of November she was admitted into St. Luke's Hospital, where she remained a little more than two months. Extension was kept up during the whole time, but without any benefit; on the contrary, all her symptoms were aggravated.

She was admitted into Bellevue Hospital Jan. 22, 1863, when the following symptoms were observable:—The right foot (see Fig. 2), when she stands erect, is elevated four inches from the floor, and very much adducted. The leg is flexed upon the thigh, and the thigh upon the hip. The pelvis is moderately distorted. When motion is attempted with the femur the whole pelvis moves as though bony ankylosis of hip-joint existed. She has constant pain at the hip-joint, which is most excruciating at night. When pressure is made it is increased. The leg is also much atrophied. Her appetite is fair, and digestion good. Extension was applied for a few days, but seeing that no good result



Fig. 2.

followed the treatment Dr. Sayre proceeded to operate (Jan.

* The cut, Fig. 1, gives a very good representation of my hip splint, as manufactured by Messrs. Otto & Kynders, No. 58 Chatham st.

29th) by subcutaneously dividing the gracilis, adductor magnus, longus, and brevis. The wound was immediately covered with adhesive plaster to prevent the introduction of air, and moderate extension applied to the parts. When comparing the length of the two legs the diseased one is found to be only an inch shorter than its fellow. Jan. 30.—The extension relieves her from all pain; before the operation it would have been torture to have kept it applied so continually. She eats and sleeps well. Feb. 2.—The wound made by the operation is now closed, consequently the straps are removed. As long as the extension is kept up she feels perfectly well, but when it is taken off and allowed to remain off her former pain shows itself. Her appetite and digestion are excellent. Feb. 16.—The extension has been continued since the operation without pain. Functions well performed. Dr. Sayre's splint was

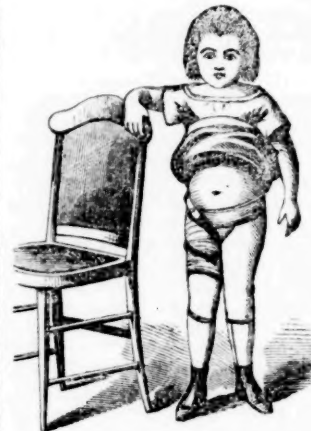


Fig. 3.

applied this afternoon, when she walked off with the aid of a crutch without difficulty. Discharged.

April 4.—The patient was brought to the hospital to-day to have her dressings re-applied, they not having been changed since she left the institution. The improvement which has taken place is most marked. Instead of the peevish, irritable disposition which she showed when first admitted she now presents a pleasant appearance, and has the glow of health on her cheeks.

Her mother states that

she has not even complained since she left the hospital. Her appearance and improved position are well represented in Fig. 2, which was taken from a photograph taken at that time.

CASE III.—Jane S., of Chicago, aged 6, was perfectly healthy until four years of age. After running very severely two years ago she came to her mother complaining of very severe pain in her right hip. She was confined to her bed for some days, suffering great pain, and could not bear any movement of the limb. After a few weeks' perfect rest she got around, and walked well for some time.

About a month after she began to have pain at night, particularly in her knee. Dr. Brainard saw her and pronounced it hip-disease, and put her in a splint. Other physicians saw her, who disagreed with this diagnosis.

The disease continued to progress, and after one year she came to New York in 1862, and was placed under the care of Drs. Parker and Sands. They applied extension with a splint, which relieved her very much indeed, and in six or eight weeks she was so much better that they advised her to leave it off, and she returned home, as it was thought, cured.

After a few weeks of exercise with the joint unprotected by extension, she again began to complain of pain in the knee and hip, and in a very short time was much worse than at any other period of the disease. Extension was again applied, which so aggravated all her symptoms that the physician in attendance concluded it could not be a case of morbus coxarius; and after this there was great diversity of opinion, no two hardly agreeing in a diagnosis. She was again brought to New York in March, 1863, and placed under the care of Dr. Peaslee.

I saw her in consultation with Dr. Peaslee, and found her in the advanced period of the second stage of the disease—the thigh flexed on the pelvis, and leg on the thigh,

limb everted, elongated, rotated outwards, and immovably fixed in this position. Any attempt to move it in any way caused intense suffering, showing that the ankylosis was from muscular contractions only. Extension could not be endured, and produced as much pain as pressure. The pelvis tilted forward, and the spine was much curved. Emaciation, loss of sleep and appetite, and all the other constitutional symptoms were such as we always find at this period of the disease.

On the 10th of March, 1863, assisted by Dr. Peaslee, I divided the adductors, the sartorius, tensor vaginae femoris, and long head of the rectus femoris muscles sub-cutaneously, closing the wounds with adhesive plaster and a snugly applied roller.

She was under the full influence of chloroform during the operation, and before she had entirely recovered from the anæsthetic the limb gradually assumed its natural position *voluntarily*, without any manipulations with the hand whatever, done of course by the natural contractions of the remaining muscles, which were now left free to act. The pelvis became square, and the limbs of equal length; the curve in the spine was removed, and the anterior superior spinous processes of the ilium became parallel instead of oblique, as they were before the operation, the right one being more than an inch lower than the left. Upon taking hold of the limb all the movements of the hip-joint were perfectly free, and by a very slight extension could be produced without pain.

She was placed in bed with the weight and pulley as usual, and 2lbs. weight applied; this weight has been gradually increased to 5lbs. She slept perfectly quiet all night without any opiate, and has not taken a narcotic of any character whatever since. The wounds all healed in a few days without suppuration, and her general health improved so rapidly that when Dr. Peaslee saw her at the end of three weeks he was much surprised at her remarkable increase of flesh.

She has not lost a meal or a night's sleep since the operation, and in fact has not made a single complaint of any pain whatever, and is now running around with the instrument applied the same as the cases above reported.

My object in publishing this case is to show the importance of keeping on the instrument for a long time after all evidences of the disease have disappeared. In fact, then is the time that it is of the greatest good, as it admits of freedom of motion to the joint, while the child can take exercise in the open air for the purpose of invigorating the general health, and at the same time the joint is guarded from pressure, and thus secured against a relapse; and this should be continued for many months, or even a year or more after they are entirely well.

795 BROADWAY, April 10, 1863.

CASE OF PUERPERAL TETANUS.

By JONATHAN HAVENS, M.D.,

OF SPARTA, N. J.

As "obstetrical tetanus" is of rare occurrence the following note may be of interest to your readers:—I was called, January 26th, to see Mrs. T., aged twenty-five, the mother of two children. On the preceding Monday, just after an attack of mumps, she had had a miscarriage, being then three months pregnant. She was attended at that time by a midwife, who was certain the placenta and membranes came away. I could not detect them by digital examination. She had been flowing a little all the week. I left her five grain doses of the acetate of lead, to be given every four hours. Jan. 28th.—The hæmorrhage had slightly increased this morning, and as she began to suffer from the loss of blood I introduced the tampon, and left her five grain doses of gallic acid, which she was to take instead of the lead. Jan. 29th.—I removed the tampon, and notwithstanding hæmorrhage had ceased I continued the acid, but less frequently. Jan. 30th.—No hæmorrhage or

offensive lochial discharge; no tenderness of uterus. I now discontinued the acid, and allowed a diet of milk, eggs, and beef. Feb. 1st.—I found her doing well, and left the muriated tincture of iron to be taken in ten drop doses three times a day. I found her (Feb. 4th) still improving, and now discontinued my visits. I was called again the second day after, as there was a return of the hæmorrhage. It was, however, but slight. I left her the fluid extract of ergot, of which ten drops were to be taken every four hours. Feb. 7th.—I was called in the evening. The hæmorrhage had ceased. In the morning she had felt a stiffness of the jaws, and thought it was a return of the mumps. I found her with some difficulty of deglutition, and the muscles of the jaws were stiff. The head was occasionally drawn back in tonic spasm. I gave her one-third of a grain of morphine, which I repeated in two hours, under the influence of which the spasms were less frequent and painful. I left one-fourth of a grain, to be given every two hours. She was directed to have liquid and concentrated nourishment and brandy, but did not take much on account of the dysphagia. Feb. 8th.—The spasms were yet confined to the neck and jaws, but were much more frequent and severe. I directed a turpentine enema, and continued the treatment as before. The day following I found the pulse more frequent and feeble, and there was no opisthotonos. Deglutition was impossible. The diaphragm was not affected. I then administered chloroform, of which a small quantity gave her great relief. I taught an attendant how to use it, and directed it to be continued, and nutritive enemata, with sixty drops of laudanum, to be given every four hours. She died early the next morning. No autopsy was made. The case was a novel one to me, but I have since found a valuable contribution on the subject by Prof. J. Y. Simpson, in *Braithwaith's Retrospect*, part 29, page 65. To this I refer your readers, without any remarks upon the case.

Reports of Societies.

UNITED STATES ARMY MEDICAL AND SURGICAL SOCIETY, OF BALTIMORE.

STATED MEETING, Feb. 26, 1863.

SURGEON C. C. COX, U.S.V., PRESIDENT, IN THE CHAIR.

DISCUSSION UPON TETANUS.

[Reported by DR. GEO. H. DARR, Acting Asst. Surg., U.S.A., Secretary.]

DR. CADDEN stated that he had nothing new to offer on the subject of tetanus, that it was a disease more frequent in warm than cold climates. He spoke of the two varieties, idiopathic and traumatic, and of trismus as a partial form, giving the marked symptoms, and defining opisthotonos, emprosthotonos, and pleurothotonos. The diagnosis between the idiopathic and traumatic forms was to be made by the history of the case, presence or absence of a wound, etc., but when the disease was fully developed both forms manifested the same symptoms and required the same treatment. The only diseases with which tetanus could be confounded were hydrophobia, poisoning by strychnia, and hysteria. The diagnosis was to be governed by the circumstances of the case. Tetanus was liable to result from any kind of wound, particularly lacerated or punctured. He remarked that the treatment of this disease was unsettled and unsatisfactory, death resulting under any treatment in the great majority of cases, especially in the traumatic variety. Autopsy threw little or no light on the pathology of the disease; the neurolemma of the nerves leading to and from the wound was sometimes found inflamed. Little was known of the pathology of the disease, except that it was an affection of the excito-motor system of nerves.

I. OPISTHOTONOS PRODUCED BY PRESSURE UPON THE SUBSCAPULAR NERVE.—II. TETANUS TREATED BY WOORARA.

ASST. SURGEON UHLER read reports of two fatal cases of traumatic tetanus.

I.—A stout Irishman, 50 years of age, wounded at the battle of Fair Oaks, came under Dr. Uhler's care at the Annapolis Hospital, presenting the usual symptoms of traumatic tetanus well marked. He was put under the influence of chloroform in order that the wound might be examined. This was situated on the side of the chest, about three inches below the axilla, and extended between three and four inches in depth. The ball remained in, and all attempts to find and extract it failed. A warm cataplasm containing opium was applied, and opium with tartar emetic given internally; the bowels, being constipated, were moved by enemata, and nourishment in a fluid form was forced freely down him with considerable difficulty. Three hours afterwards the disease had made still greater advances, and opisthotonos was plainly marked. The body was covered with a profuse perspiration, and upon the slightest touch he would start and lapse into a stronger spasm. He was now given chloroform freely by inhalation, but died within three hours without the spasms relaxing to any beneficial extent.

Post mortem examination revealed in a most beautiful manner the seeming cause of the disease. The ball, a round one, had broken off a piece of the scapula an inch and a half in length, and imbedded itself, with the piece broken, beneath the outer edge of the scapula, pressing upon the longer or lower subscapular nerve. The case was confirmatory of Baron Larrey's remark, "That a wound of the posterior nerves produces opisthotonos, that of the anterior, emprosthotonos."

II.—A small, scrofulous-looking mulatto boy, 14 years old, broke his arm near the middle. The case happening in the country, he was conveyed in a vehicle to the nearest practitioner, who put a bandage on the arm and applied splints. As the mother was coming to the city, he directed her to take the boy to a physician and get him to examine the arm to see that the bandage was not too tight. Engrossed in business she forgot the boy, whom she had left in a wagon, and swelling supervening gangrene ensued. He was admitted into the Baltimore Infirmary. Prof. N. R. Smith amputated the arm at its upper third. On the next day tetanus, manifested by the usual symptoms, supervened. The ordinary remedies having been administered without benefit, Prof. Hammond, now Surgeon-General, proposed to use woorara. Accordingly he introduced three drops of a strong solution into the areolar tissue of the thigh, and stood ready to resort to artificial respiration when the functions of the lungs should cease. The pulse, which was very rapid, immediately began to fall, and in the course of ten minutes came down to forty-five; during ten minutes more it continued to fall more slowly till it entirely ceased, twenty minutes after the introduction of the drug. The patient died in this case either from exhaustion or from the influence of the woorara, which appeared to be exerted upon the circulation, and not, as is ordinarily stated, upon the respiration.

TETANUS TREATED SUCCESSFULLY BY IMMERSION.

SURGEON C. C. Cox reported a case treated successfully by immersion in the river. A large, muscular, colored man had fallen into the fire. The burn extended over the whole of one side of the neck and corresponding arm. He was brought forty miles to be put under the care of Dr. Cox. Dr. C. had given directions that only a part of the burn should be dressed at a time. This precaution was neglected, and tetanus resulted, probably from the cold air acting on so large a raw surface. Being a large muscular man, the paroxysms were correspondingly strong and violent. Chloroform was administered in large quantities by inhalation at every paroxysm to complete anaesthesia, and opium in full doses. For two days and a half the chloroform seemed to be of benefit and to partially control

the spasms; at the end of that time it lost its power. Having heard that horses had been cured of tetanus by driving them into the river, Dr. Cox determined to try immersion in this case. The patient was taken by two strong negro men to the adjoining river and plunged in, then taken back and wrapped up in bed, perspiration being promoted. The paroxysms were evidently modified, and their violence diminished. This practice was continued three or four times a day for several days, during which the disease gradually subsided, and the man recovered. Dr. Cox stated that the good effects of every immersion were unmistakably apparent. He attributed the good effect of the cold douche to its sedative action on the spinal system of nerves. Dr. Cox made some remarks on trismus neonatorum, stating that sometimes it assumed an epidemic form in India. He adverted to the proposed method of cure by laying the child on its side in order to avoid pressure upon the occipital bone.

TETANUS SUCCESSFULLY TREATED BY ACETUM OPII, ETC.

SURGEON L. QUICK, U.S.V., reported two cases of traumatic tetanus.

I.—Private J. L. Lamer, *et.* 25 years, had enjoyed good health, except occasional attacks of remittent fever, previous to enlistment; was wounded at the battle of Williamsburg, May 5, 1862, in the shoulder. Admitted into the Adams' House Hospital May 10th. A gunshot wound was found, the ball having entered at the humeral insertion of the deltoid, and passed upwards and outwards. The medical officer in charge of the case extracted a large mass of lint from the wound. Condition on admission pretty good. May 20.—He complained of what he called cramps in the abdomen, extending posteriorly towards the sacrum and down the legs, also of headache. He was ordered the usual treatment for colic. May 23.—The patient showed some tetanic symptoms, opens his mouth with great difficulty, and was occasionally attacked with spasms affecting nearly his entire muscular system. Ordered: R. Chloroform, spts. ammon. aromat., aa , $\frac{5}{8}$ ss.; aque camph. $\frac{5}{8}$ ii. M.S. Dose, a teaspoonful every third hour. May 24.—No improvement; muscular rigidity continues, bowels constipated; ordered enemata, pulv. camph., grs. iii., pulv. opii, gr. i., every fourth hour; doses to be alternated with the previous medicine. May 28.—Dr. Quick took charge of the hospital. Patient much the same; sudamina have appeared over the chest and abdomen. Has almost continuous spasm of the abdominal and diaphragmatic muscles. Has had retention of urine, rendering the catheter necessary. Acetum opii (\mathcal{M} .x.) is substituted for the camphor and solid opium; the chloroform mixture still continued, with the addition of one drop of chloroform to each dose. Is allowed milk-punch and whatever nourishment he can take. Trismus is very decided, pulse feeble and frequent, bowels do not move except through the action of enemata. Wound is dressed with a strong solution of sulphate of morphia; it looks healthy and is healing. May 29.—Some improvement; patient has slept better; rigidity of muscles somewhat less. The doses of chloroform increased one drop daily at each dose. June 1.—Patient still improving, is more cheerful; muscular spasm less; trismus less; catheter still necessary. June 2.—Looks better than he has during the period of his tetanic attack; has passed his urine once voluntarily, takes more nourishment; sudamina disappeared. The acetum opii has been gradually increased to \mathcal{M} .xx. at a dose, and the chloroform to seven drops more at a dose than at first. June 10.—Muscular rigidity still continues, but the patient is able to open his mouth wider; the spasms are much less frequent and severe. June 11.—The patient passes his urine without difficulty; requires to urinate frequently; his appetite is better, and he is in every respect much improved. He is allowed beef essence and milk *ad libitum*. His wound is granulating slowly; treatment continued. June 20.—Patient is able to sit up; is feeble, but rapidly convalescing; wound nearly healed. June 29.—The patient has abandoned the use of medicine.

Is entirely recovered, except some stiffness of the elbow of the affected side. He walks about, and is in every respect cured of tetanus. Dr. Quick stated that the difference in effect between the pulv. opii and the acetum opii was in this case most marked and decided. Dr. Quick remarked that the notes of this case had been furnished by his able assistant, Dr. Wm. E. Small.

II.—While Dr. Quick was engaged to attend the workmen during the widening of a tunnel on the Philadelphia and Reading railroad, one of the workmen received a lacerated and contused wound of the foot by the falling of a small but sharp stone from the roof of the tunnel. Considerable bleeding followed the receipt of the injury, which was arrested by a compress. Secondary hæmorrhage took place, but it was stopped without tying the vessel. Ten days afterwards the man went home ten miles distant on the cars, the wound nearly healed, and looking well. He had no pain, there was no mark of inflammation about the wound, and no foreign substance in it.

Thinking himself well he undertook to walk two miles few days after his return home. A few hours afterwards he was attacked with symptoms of tetanus, and died within forty-eight hours.

With regard to the treatment of tetanus Dr. Quick thought too much stress could not be laid on the propriety of giving liquid instead of solid medicines, the stomach would not appropriate powders, but the absorption of liquids would go on as rapidly as before. For this reason he preferred the use of the acetum opii, and he recommended the free use of nutritious food in a fluid form with tonics and stimulants, and the cautious but bold use of such antispasmodics and sedatives as may be suited to the case. He disapproved of the use of tobacco, enemata, tartar emetic, and other such depressing agents.

(To be Continued.)

FOREIGN CORRESPONDENCE.

LETTER XXXIII.

By PROF. CHARLES A. LEE.

BOLOGNA.

Oct. 28, 1862.

THERE are many institutions in Bologna deserving the attention of the medical man, and which will reward the careful and diligent observer. It is one of those interesting provincial capitals which no country but Italy possesses in such abundance. With its rich and varied colonnades, affording a pleasant shelter from the sun and rain, with clean and well paved streets, noble institutions, and a flourishing, intelligent, and learned population, it may truly be said to rival Rome in all except classical and religious interest, and the extent of its museums. Bologna has always been the most flourishing and the most advanced in an intellectual point of view of all the cities of the Papal States, and since it has been annexed to the kingdom of Italy by the free and universal vote of its inhabitants, it has taken a still more rapid stride in the march of prosperity and intellectual progress. It has never been the residence of a Court or the seat of a Sovereign, but it has always enjoyed ample privileges and perfect freedom of manners, opinion, and speech. Far back in the middle ages the city became independent of the German emperors, and in 1112 acquired an acknowledgment of its independence, and a charter granting to its citizens the choice of the consuls, judges, and other magistrates. The possession of such valuable political privileges has had a most important influence in promoting freedom of thought and individual activity among its inhabitants. In the history of painting the *School of Bologna*, so called, occupies a most prominent place, and numbers among its masters some of the greatest names connected with the art. The names of Guido, Domenichino, and the Caracci must for ever live among those of the great painters of all time. There is also a flourishing College of Architecture here,

where pupils are educated till their twentieth year; also an Academy of Music, which is peculiarly appropriate to a city which has the credit of being the most musical in Italy. This institution is over two hundred years old, and has in its library over 17,000 printed volumes of music, and the finest collection of manuscript music in the world. Here may be seen illustrations of all the musical instruments ever invented.

Bologna is the well known seat of one of the most ancient and celebrated universities of Italy. It was founded as early as 1119, and was the first to confer academical degrees. In 1262 there were no less than 10,000 students collected here from all parts of Europe, so that it became necessary to appoint regents and professors for the students of each country. Here the Justinian Code was first taught, and from here a knowledge of Roman law first spread over all Europe; at first the science of law only was taught, but before the commencement of the fourteenth century, the faculties of medicine and arts were added. The theological faculty was instituted some years later. This was the first school in Europe where dissections of the human body were practised, and anatomy publicly taught. It was within the walls of this institution that that form of electricity known as Galvanism was discovered by Galvani, one of its professors, and whose bust and monument now adorn one of its halls. It has also given a splendid example of justice and liberality in conferring its honors on all the truly meritorious, regardless of sex. Hence in the fourteenth century it permitted the celebrated Novella d'Andrea to occupy the chair of her father, the distinguished canonist, and after her Christina de Pisan filled a professor's chair, although her beauty was so great that a curtain was drawn before her, so that she might not distract the attention of the students.—"Lest if her charms were seen, the students should let their young eyes wander o'er her, and quite forget their jurisprudence." Still later Laura Bassi became professor of mathematics and natural philosophy. She was created doctor of laws, and many ladies of France and Germany, who were members of the university, attended her lectures. And what is still more worthy of note, at a more recent date still, Madonna Mazolino graduated in medicine and surgery, and was made professor of anatomy, and taught the science to thousands of young men, with great élat; and within the present century Matilda Tambroni was made professor of the Greek language, and filled the chair with eminent ability. When we reflect upon such an illustrious example set by this world-renowned university, we may well blush at the illiberality of American colleges, who will not even admit females to share in the instructions they were founded to impart!

I am indebted to the present librarian, Liborivus Vegettus, the successor of the renowned polyglot Mezzofanti, for his kind civility in showing me through every department of the university, and giving me all needed information in regard to its present condition and prospects. At present the medical department is more flourishing than either of the others, and its professors rank among the very ablest men in Europe. Its reputation as a clinical school was a good deal owing to the labors of Tommasini, and although he has since removed to Parma his reputation has been well sustained by his successors. The number of students at present does not vary far from eight hundred. From all I have seen and heard I am satisfied that in no part of the world is every department of medical science more thoroughly taught than in this university. Certain I am that no institution can boast of richer and more extensive collections in every branch of medicine and natural history than this. I have seen most of the great anatomical and pathological museums of Europe, but I have seen none that for completeness, variety, rarity, and skilful preparation and careful and successful preservation, will compare with this.

The preparations, both natural and artificial, illustrating every branch of pathology, external and internal, and

every department of anatomy, human and comparative, are quite unrivalled both in number and excellence, and the same may be said of obstetrical science and anatomy. There are, I should judge, a dozen or fifteen large rooms of the noble palace Cellesi, now forming part of the university building, filled with these preparations, all systematically arranged, and in perfect preservation. The collection of monstrosities, human and comparative, is quite unique, and serves to illustrate every variety of malformation and deformity hitherto described. There is an immense collection of calculi, illustrating every form of concretion both in man and the lower animals. Nor are the collections in natural history less complete. Mineralogy, geology, zoology, in every department, conchology, botany, etc., etc., all are illustrated by the most ample and perfect collections to be found on the continent. I was delighted also to see here the original herbarium of Ulisse Aldrovandi, and see the botanical drawings made and colored by his own hand, certainly no mean specimens of pictorial art; also to examine some of the two hundred folio volumes of scientific manuscripts which he left behind! I saw also old Avicenna and Dioscorides in Arabic manuscript, and a terrestrial globe six feet in diameter, made one hundred years ago by Petrus Rosini, a monk, in which all countries, seas, etc., were accurately delineated with the pen. In connexion with the university are several hospitals, a clinical hospital, a veterinary college, botanical garden, etc. The *Ospedale della Vita*, or *Ospedale Grande*, is the largest in the city, containing probably fifteen hundred beds. It is situated just on the borders of the city, at its southern suburbs, and is bordered on one side by extensive grounds and gardens, to which convalescent patients are admitted. The buildings are large, and surround a court in which are the usual fountains, etc. Though probably constructed for monastic purposes they are admirably adapted for hospital uses. The wards are very spacious, clean, and perfectly ventilated, and the same may be said of nearly all hospitals I have seen in Italy, as at Venice, Padua, Vicenza, Verona, Mantua, Reggio, etc. It is beautiful to see with what tenderness, assiduity, and skill the poor patients are treated, and we learn many useful lessons from these people, whom we are apt to regard as ignorant, superstitious, and bigotedly attached to all sorts of delusions and errors. I have never seen so much time spent by the visiting physicians in their daily rounds as in Italy, nor such intense devotion to their duties, nor such extreme cautions in forming a diagnosis, nor such carefulness in writing out prescriptions, nor such tenderness on the part of nurses. Were I to seek for a cause to explain all this, I should certainly not fail to find it in the cultivation of a deeper religious spirit, a more profound conscientiousness, a quicker sense of duty, a feeling of greater responsibility; and I shall leave Italy with a full conviction that in all that concerns humanity, benevolence, and charity, she stands in the van of nations, and deserves the plaudits of mankind. I observed some typhoid and typhus fever cases in the wards, but the house-physician remarked that the city was unusually healthy, and that they had fewer patients than usual at this season of the year. As to Italian practice it seems to me generally judicious and skilful. Some think they carry the depletory practice too far in some cases, and considering the kind of patients they chiefly have to treat in hospitals, viz. the poorer classes, who often suffer for want of sufficient food, there is probably some foundation for the opinion. The physicians of Italy, however, are well read and habitually studious; they are keen observers, and have logical, philosophical minds, and no one can believe they would pursue a course of practice which their own experience and observation show to be prejudicial. I believe the fact to be, that they deplete far less than is generally supposed. I know from examining the books in different Italian hospitals, that wine is habitually given to more than two-thirds of their patients.

I shall send you some communications on the medical

institutions of Berlin, Vienna, Venice, etc., hereafter. At present you could not find room for them in your pages.

American Medical Times.

SATURDAY, MAY 9, 1863.

GRATUITOUS MEDICAL SERVICES TO LIFE INSURANCE COMPANIES.

THE medical profession has the reputation, at least among its own members, of being greatly overworked and miserably underpaid. It is true, even of those services for which medical men are promptly and fully paid, that the physician receives a smaller compensation than any person who brings to the discharge of duties special knowledge; he ranks below many classes of artisans. But we must add the fact that much of the time his services are confessedly rendered gratuitously. All the poor are his patrons, and by far the most exacting patrons that he can claim. Their demands upon his time are constant, and their calls are always imperative. Finally, if there is a public institution which requires a medical attendant, this service must also be gratuitous, though the governors or commissioners who control its affairs receive large salaries. It is not our intention now to pass in review the instances of extortion practised upon our profession, but to notice one in particular where reform is needed, and which medical men should unite to obtain.

Life Assurance Societies are wealthy organizations which receive large incomes from their business. Many of these corporations have amassed immense wealth, and all are in a greater or less degree prosperous. These societies are actually dependent upon medical officers for protection and success. The medical examiner is indeed the most important officer in the organization, for the prosecution of the business calls for his daily examination of applicants. The success of the whole business of Life Assurance may be said to rest most unequivocally upon the professional knowledge of the medical examiners. No Life Insurance Society would for a moment employ a medical officer of recognised incompetency. On the contrary, every such association seeks out the best educated and most reputable physician for this office, and to his knowledge of the profession intrusts its future success.

Here is a marked instance in which the prominent medical men of any given community are placed in a position to command full and ample remuneration for their services. Their patrons are wealthy and powerful, and bestow large salaries on other important officers. The medical examiner ranks among the first in point of real consequence, and brings to the discharge of his duties a higher qualification than any other officer, viz. the knowledge of a scientific expert. Such services in every other department of business command respect and the most liberal reward. Why do they not in a Life Insurance Co.? There is but one reason, and that is apparent on the most superficial examination of the subject. It is this: Medical men do not place a proper estimate upon their own services.

There are found in this and every community physicians in large practice taking high rank in their profession, who

ere willing to travel several miles at mid-day to attend at the offices of Life Insurances, and, after making as critical medical examinations as would be required in most obscure diseases, they accept with gratitude the paltry fee of *three, two, or even one dollar* per head. Indeed, the passion for serving these great monopolies almost gratuitously, is so strong among our leading physicians, that they struggle for the vacancies which occur with all the desperation of politicians. Instead of rejecting with scorn the miserable pittance which these companies dole out to them in the way of fees, they pocket it with an air of the most intense satisfaction. We might forgive such greed in a young man who has to struggle hard to obtain a livelihood; but in older members, enjoying sufficient incomes from their legitimate business, it is reprehensible and unpardonable.

A great reform is needed in this matter. The profession should unite in requiring that every medical examiner in a Life Insurance Company shall demand an adequate payment for his services. Instead of three dollars for each examination let him require seven or ten dollars, or still better twelve, as in English companies. In this engagement he has the power of compulsion, for no Life Insurance Association will exchange a reputable physician for one of even doubtful character. There can then be no reasonable excuse for this humiliation of the profession at the hands of the older members.

There is, however, still another method in which the profession are induced to serve these wealthy corporations, and in this instance they render their services gratuitously. To insure itself against all possible risks the Association requires the applicant to obtain from his regular medical attendant a lengthy certificate as to his predisposition to disease, etc., etc. This certificate is generally made out by the physician as a favor to his patient, when in reality it is a gratuitous service rendered to the Insuring company. They require it as an additional safeguard. The physician acts the part of a consultant, and receives nothing for his trouble and information. View this act in whatever light we may it can but be regarded as a gross imposition upon the profession, and should be resolutely resisted. The medical attendant of the applicant is entitled to his fee as a consulting physician, and should demand it without reserve. In this case, also, he has the power to demand that justice be done him, and to compel the performance of the act. His information is absolutely essential to the complete medical examination of the applicant, and the Society will not proceed without it.

The duty of the profession seems to us apparent. By concert of action individual members engaged in Life Insurance Companies should demand an adequate remuneration for their services. The question is not whether A or B can afford to leave his business, and attend at the office of the Company an hour or two daily for three or five dollars. It is rather a question which concerns the honor and dignity of the whole profession, and which no individual has the right to settle according to his own necessities. In this matter he is bound to consult the interests of his calling, and this calling demands of every member that he sustain in his own person its claims as an exalted scientific pursuit. It is equally clear that every physician should positively refuse to make out a certificate for insurance for his patient unless he is paid by the Company a full consultation fee. By declining this gratuitous service he does no violence to his relations with his patient, and will demand

only what is just and right. If the profession will unite, these most desirable objects can readily be obtained.

THE WEEK.

WASHINGTON CITY, the National Capital, is undoubtedly in the most insanitary condition of any city in the United States. The principal sources of uncleanness are thus given by DR. HENRY G. CLARK, of the Sanitary Commission, in a letter to the military authorities, recommending the adoption of appropriate measures:—

"1st. The accumulation of large numbers of men and animals in confined locations. 2d. The accumulations of filth, such as vegetable and animal offal, consequent on the above. 3d. The entire neglect of cleansing operations in the yards, lanes, and streets of the city, especially the very deficient drainage. 4th. The nuisance of a shallow, and neglected, and filthy canal in the heart of the city, a receptacle of the sewers, and a place of deposit for dead horses, etc. 5th. The marshy and stagnant water in many vacant lots, some of them—as in North Capitol street—near large hospitals, the want of drainage of which has rendered many parts of the city, as that near the President's House, malarious spots, producing intermittent and remittent fevers, jaundice, etc. 6th. The accumulation of the sick in large numbers is a very powerful means, unless proper sanitary measures are taken, of intensifying all the ordinary and extraordinary causes of disease."

The recommendations of DR. CLARK embrace a rigid system of sanitary police, which the nation is interested in seeing enforced.

THE *Chicago Medical Examiner*, the Editor of which, PROF. DAVIS, is Chairman of the Committee of Arrangements of the American Medical Association, speaks most encouragingly of the prospects of a large gathering at the next meeting. It thus alludes to the efforts to discourage the meeting:—

"Let no one, outside of Chicago, imagine that the course taken by the *Chicago Medical Journal*, and its senior editor, PROF. D. BRAINARD, in opposing the meeting of the Association, indicates any division of sentiment or action in the profession here, or that it represents the wishes or feelings of any one here but himself. On the contrary, the profession here are united, and earnestly preparing to give their brethren as cordial and pleasant a reception as they have met with in any other city in our country. Our hotels are of the best character, and amply sufficient to accommodate half a dozen 'Canal Conventions' and Medical Associations at the same time. We have full confidence that the coming annual meeting will be well attended; that its members will transact the legitimate business of the association with dignity, harmony, and profit; that they will revive and extend past associations and friendships, and by their liberality of sentiment, and their strict adherence to the proper objects of the association, they will set an example worthy of imitation by all other conventional organizations, whether religious, political, or scientific."

AN attempt was lately made on the life of a medical man in Italy, who had refused 500 francs which had been offered to him as a bribe to declare that a young conscript was unfit for military service. He was shot at by the friends of the conscript, severely wounded, and barely escaped with life.—*Brit. Med. Jour.*

DR. M'GOWAN, known as a Chinese and Japanese traveler, is about to proceed on a journey through the mountainous districts of China and Formosa.—*Brit. Med. Jour.*

Correspondence.

ON THE INTRODUCTION OF SPECIALTIES INTO BELLEVUE HOSPITAL.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR—The 20th of April, 1863, may prove to have been an important day in the medical history of our Public Institution. On that day the Commissioners of Charities and Correction, desiring to do their duty in advancing all proper means to place the poor who are obliged to seek refuge in the hospitals under their charge upon the best footing consistent with their condition, and make available all the developments under the advance and progress of medical science, took into consideration the subject of enlarging the facilities at Bellevue Hospital for the benefit of the poor of this city, for the treatment of specialties, and "in order to elicit all information in respect thereto," they addressed a letter of inquiry to the Medical Board. What answer will be given?

There was a time when all science, physical and metaphysical, could be grasped by one master-mind. While human knowledge was yet limited to but a small number of principles and facts, a few elect, like a Hippocrates or an Aristotle, could sway at the same time the sceptres of Medicine and Natural Science. But as knowledge more and more accumulated, division and subdivision became necessary. Thus medicine separated as a *specialty* from its fountain-head and co-ordinate streams, the physical sciences. Thus physicians were impelled to devote themselves to special departments of medical study or practice exclusively, until to-day each branching path of the vast domain is found to lead to a mine of inexhaustible research, in which one human lifetime is but a short working hour of the delver, and it is no longer permitted even to a Humboldt or a Virchow to embrace all the immense details of our science and art.* To preserve the natural unity of the subject, to accommodate the general wants of variously constituted communities, the bulk of the profession must perhaps ever remain "general practitioners," but no one can hope to obtain preeminence in any one branch without bestowing upon that branch special attention; and even the most arduous and toilsome worker must be content to contribute a few building blocks, or it may be but a single stonelet, to the grand temple for the healing of the afflicted which holds the common altar of all physicians, specialists and general practitioners. Specialism is not without dangers. The specialist must preliminarily be a regularly educated man; other things being equal, the best general practitioner, of course, becomes the best specialist. Division may on the one hand be carried into absurd extremes, and on the other not correspond to the actual advancement of our art. But the advantages of specialism to the patient and to science far overbalance its real and presumed injurious effects. It is well known, too, that the profession of this country has long looked with suspicion and disfavor upon the name "specialty," and the character of a "specialist." The origin of the prejudice is also well known; nor was it unreasonable or unjustifiable to associate the idea of quacksalver and knave with that of specialist, as long as no regularly educated honorable member of the profession took the title; as long as ignorant and unprincipled impostors monopolized the reputable name with a disreputable game at the expense of the health and pockets of the credulous portion of the community. But, happily, that time is past. Though pretenders abound to usurp all titles, that of specialist is proudly borne by many honorable men, men of genius and enlarged medical knowledge. Verily the day of professional progressive specialty is coming,—nay, has already come. The step taken by the Commissioners of Charities and Correction is therefore a liberal

* Niemand ist im Stande, das ungeheure Detail unserer Wissenschaft ganz zu übersehen.—Virchow.

and important one. May the improvement it inaugurates soon be realized for the benefit of the sick, and the advancement of science. The medical staff of Bellevue Hospital, and indeed the whole profession, will doubtless heartily co-operate in the praiseworthy endeavors of the Commissioners; and whatever be the precise expression of individual views and opinions in the answer of the Board, its spirit and general import may, I think, safely be predicted!

But the Commissioners, after mentioning eye, ear, nervous and skin diseases, request a reply also to the following interrogatory:

2. Are there other diseases and *Specialties* that should be regarded as important to treat by themselves under similar provision?

THROAT DISEASES, especially affections of the larynx, should, in answer, be prominently brought forward to the Board. The frequency of their occurrence; their leading to the most serious consequences in many, and to considerable inconvenience in all cases, either terminating fatally, and often with much rapidity, or entailing difficulties of the voice, the respiration, and deglutition; the fact that the use of the laryngoscope for their recognition and treatment has recently revolutionized our knowledge of them, having transferred them from the category of *internal* and obscure to that of *external* diseases within our reach, and the little attention given thereto as yet by the profession at large; render them peculiarly suitable for such separate treatment. There is perhaps no class of patients to which even the most accomplished physicians do less justice than to the sufferers from laryngeal affections. Of this there is ample evidence afforded me at the *Clinic*, which the liberality of the Faculty of the University Medical College has enabled me to establish, and, as far as I have been informed, indeed, the experience of Bellevue Hospital proves the same thing.

I conclude with the words of the illustrious Berlin and Utrecht Professors (VIRCHOW and DONDEERS), "To specialists must we look for further advancement of the healing art!"—"Specialties nowadays are the essential conditions of the progress in science. * * * Whoever speaks of progress in medicine to-day, must needs speak of specialties!"

LOUIS ELSBERG, M.D., F.A.M.,
Lecturer on the Diseases of the Larynx and Throat
at the University.

153 West 15th street.

SOLDIERS' RELIEF BILL.

[To the Editor of the AMERICAN MEDICAL TIMES.]

SIR:—The Bill published by you in the TIMES of the 28th March, purporting to be the Army Relief Bill presented to the Legislature of the State of New York, was *never presented* to them, and was a *gross fraud*, being a rough sketch which was presented to the Governor for his approval or disapproval, most of which related to the duties of the medical agents, and was not intended as an integral part of the bill. In this imperfect condition it was sent to Surgeon-General Hammond without our knowledge, and thence was transferred to your columns.

Yours, etc.,

JOHN SWINBURNE, M.D.

ALBANY, May 1, 1863.

FOREIGN MEDICAL INTELLIGENCE.

PARIS.

THE subjects of *les eaux potables* and *le secret médical à-propos de mariage* continue to fill the columns of the Paris press, and engage most of the learned societies in long discussions. The former is of course of little consequence to us, for no two rivers on the globe differ so greatly as do the Croton and the Seine, and therefore, whatever obnoxious principles they find in their waters need not give us any concern. But *le secret médical* is of a very different

nature, and demands our debates as well as theirs. The subject presents so many phases that it is difficult to know how to introduce it, unless by relating the following episode which happened in Montpellier some few months ago.

M. Delpech, a professor of eminence, having heard that the daughter of a dear friend was about to marry a young man who he knew had but one testicle, resolved for her sake (?) to make it known. Thereupon he informed the lady's father, who at once ruptured engagements, and forbade the gentleman to pay further addresses to his daughter. Thus disappointed the thwarted lover studied now but to revenge himself on the despoiler of his hopes, and shortly afterwards M. Delpech was found assassinated in his carriage together with his coachman, and the murderer not far distant fell by his own hand already so bloody.

Such, in brief, is the sad incident which has caused so much commotion, and set to writing and debating numerous medical philosophers, besides many others never before heard from. The text is: "What should be the conduct of a physician consulted upon the health of one of his clients *à l'occasion d'un mariage*." The gravity of this question must strike every one, and even some with alarm. We all have relations, either daughters or sisters, near and dear to us, and how important therefore to reflect on what course should be pursued to protect them against unclean and damaging advances. As their guardians we are ever ready to resent what openly assails them; consequently does it not behave us even more to preserve them from husbands whose veins are syphilitized, or whose degenerate bodies but hand down miseries to others? The case of M. Delpech was an extreme one, and although prolific of so much benefit by drawing debate upon the subject of medical secrets, the instance will probably deter many from passing judgment on men's unfitness for matrimony. Delpech, though, did not become a martyr on a good occasion, for, as a *monorchide* simply, the client informed upon was not diseased and no unworthy candidate for marriage, which point palliates in some slight degree the infliction of so dreadful a revenge. The opinions of the savans upon the text are at great variance: one party says, preserve the secret, while another says, preserve pure blood. The doctor is priest, say some, and like him is sustained by all holy and common laws in holding inviolate any and all knowledge of his patients' infirmities: *Non facienda mala ut inde eveniant bona*.

The doctor is at liberty, say others, and even morally obligated, to impart his secret knowledge when called upon as in a question of marriage. In this dilemma the Hippocratic oath is brought forward, which, strange to say, was found to give support to both sides. The Scriptures, it is true, admit of many versions, and thus comfort and oblige mankind, but who has heard that the Hippocratic oath can be turned to accommodate two sets of differing doctors? To prevent any doubt on this point here follow the two renderings:

"Admitted to the interior of families I swear that my eyes will not see that which passes, and that my tongue will not impart the secrets in me confided."

"The things which I may see or may hear said in the exercise of my art, or outside of such functions in my intercourse with men, and which should not be divulged, I will hold silent, and regard them as inviolable secrets."

The foregoing is almost literal from the French, and as the present writer has not at hand the oath in its original text he is not qualified to decide which version is right, or if *toutes les deux* are wrong. In conclusion, this is about as far as the Parisians have got, and, to use a political phrase, as there are no signs of immediate settlement intervention would doubtless be acceptable. Tell us, then, ye sages, "What is to be done with the secret?" CYGNET.

ILLINOIS STATE MEDICAL SOCIETY.—The regular annual meeting of the State Society is to be held in Jacksonville, on the first Tuesday in May.

Army Medical Intelligence.

MEDICAL REGULATIONS DURING BATTLE.

SURGEON-GENERAL'S OFFICE,
WASHINGTON, D. C., March 25, 1863.

In order that the wounded may receive prompt and skilful attention during and immediately after a battle, the following instructions, compiled in part from a circular issued by the Chief Medical Director of the Army of the Potomac, October 30, 1862, are published for the information and guidance of medical officers:

1. Before a battle, the Chief Medical Director, and the Medical Directors of Army Corps, will consult and co-operate with the officers of the Quartermaster's Department in making the necessary arrangements for the transportation of the wounded, and in instructing the drivers and assistants in the service of the ambulances and litters.

2. The Chief Medical Director will have the general superintendence of the whole ambulance and hospital service, and will give such orders for the removal, accommodation, and surgical treatment of the wounded as may be necessary. After a battle, he will cause the wounded to be removed to the permanent general hospitals, as soon as it is proper to do so, and no wounded man will be sent away from a field hospital without his authority.

3. As soon as practicable after a battle, the Chief Medical Director will transmit to the Surgeon-General a report of the action, describing the nature of the battle, the numbers engaged, the character and range of the enemy's fire, and the period and mode of removal of the wounded. He will state the number and location of the division hospitals, their organization and supplies, and also whether the wounded were promptly provided with food and blankets. He will transmit with this report a consolidated tabular statement of wounds received and operations performed. (See tabular statements, monthly report of sick and wounded.) Should deaths occur from anesthetics, they will be reported in detail.

4. Medical Directors of army corps will apply to their commanders, on the eve of a battle, for the necessary guards, and men for fatigue duty. These guards will be particularly careful that no stragglers be allowed about the field hospitals, using the food and comforts prepared for the wounded.

5. Previous to an engagement, each Medical Director of an army corps will detail a proper number of medical officers to remain and take care of the wounded, should a retreat be necessary. This detail he will request the corps commanders to announce in orders.

6. Medical Directors of army corps, acting under the orders of the Chief Medical Director, will exercise a general superintendence over, and direction of, the medical service of their respective corps. They will establish division field hospitals in the most convenient and secure positions, with ready access to water and fuel, and in buildings, where suitable ones can be obtained.

7. Medical Directors of corps will see that the division hospitals are properly organized and provided with the necessary medicines, instruments, stores, and furniture.

8. They will see that the ambulances which follow the troops to succor the wounded and remove them from the field, have the necessary attendants, litters, and litter bearers, so that soldiers may have no excuse to leave the ranks for that object.

9. The Surgeon-in-Chief of each division will exercise general supervision, under the Medical Director of the corps, over the medical service in his division. He will see that the officers and attendants are faithful and efficient in the discharge of their duties in the hospital, and upon the field, and that the wounded are removed from the field carefully, and with despatch.

10. He will organize the division hospital as follows:

1st. A surgeon-in-charge; one assistant-surgeon to pro-

vide food, fuel, and water, and one assistant-surgeon to keep the records.

2d. Three medical officers, to constitute the operating staff of the hospital; three medical officers as assistants to each of these officers.

3d. Additional medical officers, hospital stewards, cooks and nurses of the division.

11. The surgeon-in-charge will have the general superintendence, and be responsible to the division surgeon for the administration of the hospital. It will be his duty to have the hospital tents properly pitched, and when houses are used, to have them put in proper order for the reception of wounded. He is to provide the necessary medical and hospital supplies, operating tables, straw or hay for bedding, blankets, and rations.

12. The assistant surgeons, who are under the immediate orders of the surgeon-in-charge, will aid that officer in preparing the hospital for the reception of the wounded. That duty performed, one assistant surgeon will organize and take charge of a kitchen, using for this purpose the hospital mess chests, and the kettles, tins, etc., in the ambulances. The supplies of beef-extract and bread in the ambulances, and of extract of coffee, tea, condensed milk, and other hospital stores in the hospital supply wagons, will enable him to prepare quickly a sufficient quantity of palatable and nourishing food to meet the demands, until fresh beef and other subsistence stores can be provided. All the cooks, and such of the hospital stewards and nurses as may be necessary, will be placed under the orders of this assistant-surgeon.

13. The other assistant-surgeon will keep a complete record of every case brought to the hospital, giving the name, rank, company, and regiment; the seat and character of injury; the treatment; the operation, if any performed; the name of the operator, and the result. This record will be transmitted by the division surgeon to the Medical Director of the corps, and by him sent to the Chief Medical Director.

14. This assistant-surgeon will make out two "Tabular statements of wounded," one of which the division surgeon will transmit, within forty-eight hours after a battle, to the Chief Medical Director, and the other to the Medical Director of the corps.

15. He will also see to the proper interment of those who die, and that each grave is marked with a headboard, with the name, rank, company, and regiment legibly inscribed upon it.

16. The three medical officers composing the operating staff will be selected by the division surgeon, without regard to rank, but solely on account of their known prudence, judgment, and skill. The immediate responsibility of the performance of all important operations will rest with them. In all doubtful cases they will consult together, and a majority of them shall decide upon the expediency and character of the operation.

17. Each of these officers will have the aid of three medical officers, who, acting under his orders, will assist him in his operations.

18. The remaining medical officers of the division, except one to each regiment, will be ordered to the hospitals to act as dressers and assistants generally. Those who follow the regiments to the field will establish themselves, each one at a temporary depot, at such a distance or situation in the rear of his regiment as will insure safety to the wounded, where they will give such aid as is immediately required; and they are here reminded that, whilst no personal consideration should interfere with their duty to the wounded, the grave responsibilities resting upon them render any unnecessary exposure improper.

19. The division surgeon will order to the hospital, as soon as it is located, all the hospital supply wagons, hospital tents and furniture, and all the hospital stewards, cooks, and nurses belonging to the division. He will notify the officer commanding the division ambulances of the position

of the hospital. When his duties permit, he will give his professional services at the hospital.

20. No medical officer will leave the position to which he has been assigned without permission; and any officer so doing is to be reported to the Medical Director of the corps, and to the Chief Medical Director.

21. Medical Directors of corps and division surgeons are required to have the following articles carried in the box of each ambulance, under the driver's seat:

Beef, extract, in 2-lb. tins,	lbs. 6.
Buckets, leather,	No. 1.
Kettles, camp,	No. 1.
Lantern and candle,	No. 1.
Spoons, table,	No. 6.
Tumblers, tin,	No. 6.
Hard bread,	lbs. 10.

The boxes will be kept locked. The surgeon-in-charge of the Brigade will keep the keys, and by weekly inspections ascertain that each ambulance has its full supply. In addition to the above, each ambulance is to be furnished with two litters, and one keg filled with water.

WILLIAM A. HAMMOND,
Surgeon-General U. S. Army.

ORDERS, CHANGES, &c.

Assistant Surgeon W. H. Bidluck, 624 New York Vols., having been tried before a General Court-Martial, on the charge of "positive and wilful disobedience of orders," has been "cashiered, with loss of all pay and allowances that are or may become due him from the United States."

So much of Special Orders 119, current series, as dismissed Surgeon J. G. Buchanan, 32d Ohio Vols., has been revoked, he having been previously discharged by resignation under Special Orders No. 33, January 17, 1863, Headquarters Department of the Ohio.

Surgeon John Moore, U.S.A., has been relieved from duty in the Army of the Potomac, and ordered to report in person without delay to Major-General Grant, commanding Department of the Tennessee, to relieve Surgeon M. Mills, U.S.A., in the duties of Medical Director of that Department. Surgeon Mills to await orders to come before the Retiring Board, at St. Louis, Mo.

The resignations of Surgeon J. B. Penle, U.S.V., and Assistant Surgeon J. H. Pooley, U.S.A., have been accepted by the President.

Assistant Surgeons C. T. Alexander and E. A. Clements, U.S.A., have been promoted to Surgeons.

Drs. James Bradley, of Philadelphia, H. T. Legler, of New York, and J. H. Currey, of Maryland, have been appointed Assistant Surgeons of Volunteers, to date from March 27, 1863.

Surgeon W. H. Church, U.S.V., has been assigned to duty as Medical Director, Department of the Ohio.

Surgeon W. W. Holmes, U.S.V., has been assigned to duty as Medical Director, District of Ohio.

Surgeon J. C. Whitehill, U.S.V., has returned from leave of absence, and resumed his duties as Medical Director, at Jackson, Tenn.

Surgeon G. L. Sutton, U.S.V., has relieved Surgeon N. E. Mosely, U.S.V., as Medical Director Abercrombie's Division, Arlington, Va.

Surgeon N. E. Mosely has relieved Surgeon G. L. Sutton, U.S.V., in charge of Emory Hospital, Washington, D.C.

So much of Special Orders No. 154, current series, as dismissed Assistant Surgeon J. J. Ellis, 35th Massachusetts Vols., on the report of Colonel O. Edwards, of the same regiment, has been revoked, Assistant Surgeon Ellis having been honorably discharged by Special Orders 67 Headquarters 16th Army Corps, March 10, 1863.

The following assignments of Medical Officers have been made:

Surgeon John E. McDonald, U.S.V., to report by letter for duty to Major-General Burnside, commanding Department of the Ohio.

Surgeons C. N. Chamberlain and H. James, U.S.V., to report to the Medical Director, Army of the Potomac.

Surgeons C. W. Hornor and R. E. Taylor, U.S.V., both on duty in Philadelphia, Pa., Surgeon Peter Cleary, U.S.V., now on duty at Camp Parole, Annapolis, Md., Assistant Surgeon C. S. Frink, U.S.V., now on duty at Camp Convalescent, near Alexandria, Va., Surgeon J. W. Faye, U.S.V., and Assistant Surgeon E. J. Darken, U.S.A., to report in person to Major-General Rosecrans, commanding Department of the Cumberland, and by letter to Assistant Surgeon-General E. C. Wood, at St. Louis, Mo.

Assistant Surgeon J. T. Calhoun, U.S.A., to report for duty to Surgeon Jonathan Letterman, Medical Director, Army of the Potomac.

Assistant Surgeon L. D. Harlow, U.S.V., has been assigned to duty at Hospital No. 3, Nashville, Tenn.

Assistant Surgeon J. W. Lawton, U.S.V., has been assigned to duty at Madison, Ind.

Surgeon J. S. Bobbs, U.S.V., has returned to Indianapolis, Ind., and resumed charge of the General Hospitals at that place.

Surgeon John Neil, U.S.V., has been ordered to report for temporary duty to the Medical Director, Army of the Potomac.

Surgeon R. C. Stiles, U.S.V., has been assigned to the 2d Corps, Army of the Potomac.

Assistant Surgeon A. M. Wilder, U.S.V., has been assigned to duty at Madison, Ind.

Surgeon B. Darrach, U.S.V., is in New York on leave of absence (sick).

Surgeon A. M. Clark, U.S.A., has been assigned to the charge of the 5th Corps Hospital, Army of the Potomac.

ERRATUM.—Page 152. Alumni Association, for "David Linsly, Vice-President" read "Jared Linsly, V.-P."

METEOROLOGY AND NECROLOGY OF THE WEEK IN THE CITY AND COUNTY OF NEW YORK.

Abstract of the Official Report.

From the 27th day of April to the 4th day of May, 1868.

Deaths.—Men, 93; women, 50; boys, 142; girls, 120; total, 435. Adults 173; children, 262; males, 235; females, 200; colored, 12. Children born of native parents, 23; foreign, 200.

Among the causes of death we notice:—Apoplexy, 5; infantile convulsions, 32; croup, 19; diphtheria, 25; scarlet fever, 15; typhus and typhoid fevers, 16; consumption, 62; small-pox, 1; measles, 5; dropsy of head, 21; infantile marasmus, 18; cholera infantum, 2; inflammation of brain, 7; of bowels, 8; of lungs, 33; bronchitis, 18; congestion of brain, 0; of lungs, 0; erysipelas, 2; diarrhoea and dysentery, 5. 216 deaths occurred from acute diseases, and 31 from violent causes. 315 were native, and 120 foreign; of whom 74 came from Ireland; 34 died in the City Charities; of whom 10 were in Bellevue Hospital, and 4 died in the Immigrant Institution.

Abstract of the Atmospheric Record of the Eastern Dispensary, kept in the Market Building, No. 57 Essex street, New York.

	SIX A.M.				TWO P.M.				TEN P.M.			
	Minimum Temperature.	Evaporation.	Barometer.	Wind.	Temperature.	Evap. Below.	Barometer.	Wind.	Temperature.	Evap. Below.	Barometer.	Wind.
April												
May												
1868												
26th.	40 42	4	29.91	N.W.	55	9	29.96	W.	44	4	30.00	W.
27th.	42 46	5	30.01	N.W.	65	10	30.01	S.W.	55	6	30.01	S.W.
28th.	52 54	5	30.02	S.W.	70	9	30.00	S.W.	53	2	30.00	S.W.
29th.	50 50	1	29.80	N.E.	57	6	29.84	S.W.	53	3	29.56	S.W.
30th.	5 56	3	29.93	W.	66	7	29.91	S.W.	56	4	29.94	W.
1st.	50 50	5	30.01	N.W.	60	10	30.04	S.W.	56	6	30.05	W.
2d.	51 56	6	30.00	S.W.	68	11	30.00	S.W.	51	5	30.01	S.W.

REMARKS.—26th and 27th, Clear with fresh wind. 28th, Clear A.M., cloudy P.M. 29th, Very light rain A.M., day cloudy. 30th, Fog early; clear day; cloudy night. May 1st and 2d, Clear.

JUST PUBLISHED.

Bulletin of the New York Academy of Medicine. Vol. 1. 1861-62. 8vo. cloth, pp. 553. \$1 50. If to be sent by mail 84c. extra must be remitted. Subscriptions received for Vol. 2, 1863. \$1 00 payable in advance.

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The original "Elixir of Calisaya

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